MEDICAL SOURCE STATEMENT
NEPHROLOGY

***Instructions/ Disclosure*:** This form is intended to be completed by a treating medical provider for the listed patient. If you are unable to provide an answer to a question, please mark "N/A" or leave it blank. Please note this information will only be used in strict confidence for evaluation of the Patient's claim for disability by the Social Security Administration and will not be used in any other way. Thank you.

PATIENT INFORMATION		
Last Name:	***First Name:***	***Date of Birth:***

PROVIDER & CLINIC INFORMATION		
Provider Name:		***Area(s) of Practice:***
Clinic Name:		
Address:	***Office Number:***	***Fax Number:***
Date of Patient's First Exam:	***Date of Patient's Most Recent Exam:***	
Today's Date:		

Please complete the following questions based on your professional judgement regarding the patient's physical and cognitive limitations related to their diagnosed medical condition(s).

1. When did you first begin treating the patient and how often do you see the patient now?

2. In the order of significance, please list any medical diagnoses the patient has received and how would characterize the severity of each?

3. Please cite any objective medical evidence confirming the diagnoses:

4. Does the patient have a genitourinary disorder resulting in chronic kidney disease (CKD)? Examples of such disorders include chronic glomerulonephritis, hypertensive nephropathy, diabetic nephropathy, chronic obstructive uropathy, hereditary nephropathies, or nephrotic syndrome due to glomerular dysfunction.
If YES, please indicate the level of severity (MILD, MODERATE, or SEVERE).

5. Is there objective medical evidence <u>covering a period of at least 90 days</u> that documents the signs, symptoms, and laboratory findings of the patient's genitourinary disease?
If YES, please describe the reports of clinical examinations, treatment records, or labs:

6. What is the patient's estimated glomerular filtration rate (eGFR)?
Please provide the date(s) and value(s) of the patient's eGFR [if applicable]:

7. Has the patient had a kidney or bone biopsy? If so, please describe the results:

8. Does the patient require chronic hemodialysis or peritoneal dialysis for treatment? Yes ☐ No ☐

If YES, has the patient's ongoing dialysis lasted or is expected to last for a continuous period of at least 12 months?

Yes ☐ No ☐

9. Has the patient had a kidney transplant? **YES: ☐ NO: ☐**

If NO, does the patient need a kidney transplant? **YES: ☐ NO: ☐**

10. Does the patient have renal osteodystrophy? **YES: ☐ NO: ☐**

If YES, please indicate the level of severity and whether the patient has frequent or intractable (resistant to treatment) bone pain that interferes with physical activity or mental functioning.

If YES, does the patient have bone abnormalities, such as Osteitis Fibrosa, Osteomalacia, or Pathologic Fractures? **YES: ☐ NO: ☐**

11. Does the patient have Fluidoverload Syndrome? **YES: ☐ NO: ☐**

If YES, please describe any signs and symptoms of vascular congestion, such as congestive heart failure, pleural effusion (excess fluid in the chest), ascites (excess fluid in the abdomen), hypertension, fatigue, shortness of breath, or peripheral edema:

A. If YES, does the patient have documentation of diastolic hypertension greater than or equal to diastolic blood pressure of 110 mm Hg despite at least 90 consecutive days of prescribed therapy, documented by at least two measurements of diastolic blood pressure at least 90 days apart during a consecutive 12-month period?

   YES: ☐ NO: ☐

B. If YES, does the patient have documentation showing Signs of vascular congestion or anasarca despite at least 90 consecutive days of prescribed therapy, documented on at least two occasions at least 90 days apart during a consecutive 12-month period?

   YES: ☐ NO: ☐

12. Does the patient have peripheral neuropathy? **YES:** ☐ **NO:** ☐

If YES, please indicate the level of severity and whether the resulting neuropathy affects the patient's peripheral motor or sensory nerves, or both, causing pain, numbness, tingling, and muscle weakness in various parts of the patient's body:

If YES, has the patient's peripheral neuropathy lasted or is expected to last for a continuous period of at least 12 months? **YES:** ☐ **NO:** ☐

13. Does the patient have anasarca? **YES:** ☐ **NO:** ☐

If YES, please describe the extent of edema, including pretibial (in front of the tibia), periorbital (around the eyes), or presacral (in front of the sacrum) edema. If applicable, please provide a description of any ascites, pleural effusion, or pericardial effusion:

14. Does the patient have anorexia? **YES:** ☐ **NO:** ☐

If YES, please indicate the patient's weight and BMI on at least two different occasions:

15. Does the patient have complications of chronic kidney disease? **YES:** ☐ **NO:** ☐

If YES, please indicate examples of complications from CKD (such as stroke, congestive heart failure, hypertensive crisis, or acute kidney failure requiring a short course of hemodialysis:

16. Does the patient have reduced glomerular filtration evidenced by laboratory findings documented on at least two occasions at least 90 days apart during a consecutive 12-month period showing:

Serum creatinine of 4 mg/dL or greater: **YES:** ☐ **NO:** ☐

Creatinine clearance of 20 ml/min. or less: **YES:** ☐ **NO:** ☐

eGFR of 20 ml/min/1.73m2 or less: **YES:** ☐ **NO:** ☐

17. Does the patient have nephrotic syndrome? **YES:** ☐ **NO:** ☐

If YES, are there laboratory findings documented on at least two occasions at least 90 days apart during a 12-month consecutive period showing:

A. Proteinuria of 10.0g or greater per 24 hours? **YES:** ☐ **NO:** ☐

B. Serum albumin of 3.0 g/dl or less with
proteinuria of 3.5 g or greater per 24 hours: **YES:** ☐ **NO:** ☐
urine total-protein-to-creatinine ratio of 3.5 or greater: **YES:** ☐ **NO:** ☐

C. Anasarca persisting for at least 90 days despite treatment: **YES:** ☐ **NO:** ☐

18. Exertional Limitations
Please respond based on the maximum capacity the patient possesses to comfortably perform the exertional activity.

NOTE:
*Occasionally means 1/3rd of the time over the course of an 8-hour work period.
**Frequently means 2/3rds of the time over the course of an 8-hour work period.

Occasionally* lift and/or carry, including upward pulling (maximum):

less than 10 pounds	10 pounds	25 pounds	50 pounds	100 pounds or more
☐	☐	☐	☐	☐

Frequently lift and/or carry, including upward pulling (maximum):**

less than 10 pounds	10 pounds	25 pounds	50 pounds or more
☐	☐	☐	☐

Stand and/or walk (with normal breaks) for a total of:

less than 2 hours in an 8-hour workday	about 2-4 hours in an 8-hour workday	about 6 hours in an 8-hour workday	medically required hand-held assistive device is necessary for ambulation
☐	☐	☐	☐

Sit (with normal breaks) for a total of:

less than 2 hours in an 8-hour workday	about 6 hours in an 8-hour workday	must periodically alternate sitting and standing to relieve pain or discomfort (explain below)
☐	☐	☐

Push and/or pull (including operation of hand and/or foot controls):

unlimited, other than as shown for lift and/or carry	limited in upper extremities (describe nature and degree)	limited in lower extremities (describe nature and degree)
☐	☐	☐

19. Postural Limitations
Please respond based on the maximum capacity the patient possesses to comfortably perform the exertional activity.

NOTE:
*Occasionally means 1/3rd of the time over the course of an 8-hour work period.
**Frequently means 2/3rds of the time over the course of an 8-hour work period.

☐ **None established**	**Frequently****	**Occasionally***	**Never**
Climbing – ramp/stairs	☐	☐	☐
Climbing – ladder/rope/scaffolds	☐	☐	☐
Balancing	☐	☐	☐
Stooping	☐	☐	☐
Kneeling	☐	☐	☐
Crouching	☐	☐	☐
Crawling	☐	☐	☐

20. Manipulative Limitations
Please respond based on the maximum capacity the patient possesses to comfortably perform the exertional activity.

☐ **None established**	**Limited**	**Unlimited**
Reaching all directions (including overhead)	☐	☐
Handling (gross manipulation)	☐	☐
Fingering (fine manipulation)	☐	☐
Feeling (skin receptors)	☐	☐

21. Visual Limitations
Please respond based on the maximum capacity the patient possesses to comfortably perform the exertional activity.

☐ **None established**	**Limited**	**Unlimited**
Near acuity	☐	☐
Far acuity	☐	☐
Depth perception	☐	☐
Accommodation	☐	☐
Color vision	☐	☐
Field of vision	☐	☐

21. Communicative Limitations
Please respond based on the maximum capacity the patient possesses to comfortably perform the exertional activity.

☐ **None established**	**Limited**	**Unlimited**
Hearing	☐	☐
Speaking	☐	☐

22. Environmental Limitations
Please respond based on the maximum capacity the patient possesses to comfortably perform the exertional activity.

☐ **None established**	**Unlimited**	**Avoid concentrated exposure**	**Avoid even moderate exposure**	**Avoid all exposure**
Extreme cold	☐	☐	☐	☐
Extreme heat	☐	☐	☐	☐
Wetness	☐	☐	☐	☐
Humidity	☐	☐	☐	☐
Noise	☐	☐	☐	☐
Vibration	☐	☐	☐	☐
Fumes, odors, dusts, gases, poor ventilation, etc.	☐	☐	☐	☐
Hazards (machinery, heights, etc.)	☐	☐	☐	☐

23. Approximately what percent of time do you believe the patient would be "off task" over the course of an 8-hour day while performing work activity in a workplace environment?

10%	15%	20%	25%	Other
☐	☐	☐	☐	_____

24. Approximately how often would the patient need to miss work each month because of their medical condition(s) or for treatment thereof?

_____ days per month

25. Miscellaneous comments:

_____	_____
Provider's Name and Designation	***Provider's Specialty***
_____	_____
Provider Signature	***Date***

TO RETURN THIS REPORT

Email :	Mail :	Fax :
medical@desertdisability.com	Desert Disability PLC 7272 E. Indian School Rd. Suite 540 Scottsdale, AZ 85251	480-420-8720

PRIVACY ACT NOTICE: The information requested on this form will be used in deciding this patient's Social Security Disability Claim. Failure to complete this form may result in a delay in processing the claim. Information furnished on this form may be disclosed by the Social Security Administration to another person or governmental agency only with respect to Social Security programs and to comply with Federal laws requiring the exchange of information between Social Security and other agencies.